seeking and aggressive behaviour. Their findings could be echoed anecdotally elsewhere. Such behaviours are widely considered to be environmentally determined and are learnt and positively reinforced by the institutional environment. Following the principles of normalisation, therefore, these patients should also have been discharged. The paper reinforces our experience that despite the piety of much that is written concerning normalisation and deinstitutionalisation the general population and social services departments may be reluctant to integrate such people into the community.

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- 1 Farmer R, Holroyd S, Rohde J. Differences in disability among people with mental handicaps who were resettled in the community and those who remained in hospital. *BMJ* 1990; 301:646. (29 September.)

SIR,—Dr Richard Farmer and colleagues report that most people with multiple handicaps are not being enabled to live in the community. Community care of the mentally ill is widely recognised to be inadequate, and many are demanding that the rate of discharge of patients with mental handicaps from hospital be slowed until the infrastructure for community care is established. Few people have recognised, however, the extent to which erosion of resources in psychiatric hospitals has reduced the ability of these hospitals to provide safe care for their patients.

Recent events in one large psychiatric hospital show the position. During the 1980s patients with intractable illness remained in the hospital despite a policy of avoiding prolonged hospital stays whenever possible. In the five years 1983-88, 44 new long stay patients were admitted, many of whom had serious behavioural disturbances. Meanwhile, the more able of the long stay patients already in hospital were discharged to group homes, leaving behind those patients whose ability to care for themselves was severely impaired. Resources were diverted from the hospital to fund community oriented mental health services elsewhere and general medical services in the district without taking account of the severity of the problems of the patients in the hospital. By 1987 it was not possible to provide safe care in some wards. Eighty six patients, many with severe problems, were resident in wards that received only intermittent nursing care. During 1988-9, there were many episodes of dangerous behaviour, including serious assault and arson.

Despite this the health authority continued to close wards. In 1989 a ward was closed even though 10 seriously disabled patients were still resident in it, and these people were transferred to a ward without regular nursing care. This led to selected patients being placed in private nursing homes because there was no suitable alternative available. An inquiry found that most of the patients placed in nursing homes were receiving better care than they would have received in the psychiatric hospital, but nursing homes are not a satisfactory method of meeting the long term needs of such patients. We must recognise the needs of the fairly small proportion of mentally ill patients who have intractable illness, and provide care in settings that are homely yet capable of absorbing the consequences of seriously disruptive behaviour.

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SIR,—Professor Richard Farmer and colleagues followed up 400 people with mental handicaps living in mental hospitals in the boroughs of Kensington and Chelsea and Westminster.¹ In 1981 we made a survey to identify all the people aged 12 or more with mental handicaps known to be, or to have been, resident in the King's Cross ward of the London Borough of Camden.²

We asked the people with mental handicap, their informal carers, and their professional carers to indicate their preferred location for care in the future, drawing on the models for community care described by King Edward's Hospital Fund for London.³ Since then an NHS community support team has been established in Camden. This year we sought to trace the 28 people surveyed.

Eleven people had originally been in hospital. They were generally older patients (average age 57 (range 12-88)). We had recommended that seven live in "cluster" homes and that four stay in hospital. At follow up six had died, one had been discharged to a hostel, and four were still in hospital. The seven people that were living in hostels at the time of the survey were younger (average age 31 (20-43)). At follow up one had died, three remained in the same hostels, one was in a supported home, one lived with foster parents, and one lived independently with outreach support. Of the 10 people (average age 31 (18-52)) who had been at home or with foster parents in 1981, one had died, one lived with an adult carer, four lived independently or with their parents, and four were not known currently to our local services.

A wide range of residential provision exists. Older people more often remain in NHS hospitals, and, though carers had thought that most in our sample could have been resettled in the community, few had been. The people who were living in hostels or supported at home were younger. Their community care had been maintained and diversified, and none had been admitted to hospital. Although longitudinal studies suggest that resettling hospital patients is proving difficult, our data suggest that existing community care is benefiting both people with learning difficulties and the NHS by preventing long term hospital admissions. An expansion of NHS community care would allow more people to be resettled in the community.

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- 1 Farmer R, Holroyd S, Rohde J. Differences in disability between people with mental handicaps who were resettled in the community and those who remained in hospital. *BMJ* 1990; 301:646. (29 September.)
- 2 McCarthy M. *The Bloomsbury Project: report*. London: Department of Community Medicine, University College London, 1981.
- 3 King Edward's Hospital Fund for London. *An ordinary life: comprehensive locally-based residential services for mentally handicapped people*. London: King's Fund Centre, 1980.

Shoulder pain in the elderly

SIR,—Drs David O'Reilly and Robert M Bernstein brought attention to the many treatable shoulder conditions among elderly (and not so elderly) people.

I believe that it is important to emphasise the following points. Firstly, the importance of the coracoacromial ligament in the subacromial syndromes—impingement, tendinitis, and cuff tears—has been increasingly recognised. Shoulder arthroscopy has confirmed that the so called subacromial bursa lies in an anterior position deep mainly to the coracoacromial ligament rather than to the acromion process. The bursa is therefore most simply injected by the anterior route. The needle is inserted 2 mm lateral to the centre of the

anterior margin of the acromion, and the hip advanced until it contacts the acromion. The needle is then angled caudally until a "pop" is felt as it passes through the coracoacromial ligament and into the bursa.²

Secondly, most elderly patients with shoulder pain will have a cuff tear and the subacromial bursa will therefore communicate with the glenohumeral joint. Posterior injection of this joint is recommended. Injection should be through the soft spot 1.5 cm inferomedial to the posterior angle of the acromion. The coracoid process is felt in the deltopectoral groove and the needle advanced towards the coracoid tip: a loss of resistance is felt as the needle enters the joint.

By using these two injection techniques and injection of the acromioclavicular joint small doses of local anaesthetic can be administered to allow rapid and accurate diagnosis of most shoulder conditions.

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- 1 O'Reilly D, Bernstein RM. Shoulder pain in the elderly. *BMJ* 1990;301:503-4. (15 September.)
- 2 Strizak AM, Danzig L, Jackson DW, Greenway G, Resnick D, Staple T. Subacromial bursography. *J Bone Joint Surg [Am]* 1982;64:196-201.

Screening with discrimination

SIR,—We support the concept of a national screening body to encourage rational screening and discourage ineffective tests as proposed in Dr Howard S Cuckle's editorial.¹

In this age of cost accountability, however, we were surprised not to read anything of the useful cost benefit analyses that have been carried out on screening programmes. Screening programmes must be not only effective but efficient. The cost of implementing a screening test must therefore be reasonable, and it is even better if the cost is more than balanced by cost benefits in not having to treat the condition at a later stage.

We have studied the costs of setting up a screening programme for congenital dislocation of the hip by looking at a small group of patients who were missed by the screening programme and thus required extended late treatment, which included several operations and traction.² The cost of the treatment far exceeded the cost of early treatment in a nappy splint, and we found that the screening programme could be cost effective but only if the detection rate was increased from 50%, currently, to 63%, which would require increased screening by a team of specialised nurses.

New screening programmes should be contemplated only when they are shown to be cost effective.

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- 1 Cuckle HS. Screening with discrimination. *BMJ* 1990;301: 889-90. (20 October.)

- 2 Kernohan WG, Trainor BP, Mollan RAB, Normand CEM. Cost-benefit appraisal of screening for congenital dislocation of the hip. *Management in Medicine* 1990;4:230-5.

SIR,—Dr Howard S Cuckle fails to consider what some of us who have been concerned with screening programmes regard as one of the most important aspects—that is, whether those to be screened want to be and are likely to act sensibly when the results are positive.¹

It was depressing, if characteristic, that when the Medical Research Council agreed to fund the East Anglian study of the efficacy and desirability of screening for cystic fibrosis, evaluation of the